SANTA FE THERAPY ASSOCIATES

Speech-Language Therapy • Orofacial Myology • Occupational Therapy • Physical Therapy
1800 Old Pecos Trail • Santa Fe, New Mexico • 87505
P) 505-424-8777 • F) 505-424-9777

Melissa Wilson, M.Ed., CCC/SLP, COM - Director

Patient name:	DOB:	Today's Date:
Parent/Guardian:	Phone number:	Physician's Name:

At what age did she/he achieve the following milestones? If age unknown please note "on time/delay".

_____ Roll _____ Crawl _____ Sat up _____ Stood _____ Walked _____ Fed Self

_____ Dress Self _____ Toileted _____ Single Words _____ Combined Words

Describe concerns/problem:

How long has this been an issue? _____

Has there been any change since you first noticed the problem? _____

Please list any medical conditions/diagnoses for your child:

Child History

Were there any unusual birth circumstances? _____

Did she/he have delays in areas such as walking, toilet training, fine or gross motor development, understanding what is said to them, speaking? Please circle any that apply and explain below.

Has she/he had any SEVERE illnesses or any surgeries? _____

Has your child had any diagnostic studies (hearing/vision test, CAT scan, MRI, Swallow Study, etc.)?

Has your child seen any specialists such as Neurologist, Orthopedist, Gastroenterologist, ENT, Orthodontist? If yes, who?

Please list any medications your child is currently taking and what it is for:

Please list any allergies (including foods) your child has and their reaction:

(turn page over)

Is there any family history of speech, language, learning, sensory, motor and/or hearing problems? If so, please describe:_____

_____

_____

Does your child have any other medical history:

- □ high blood pressure
- □ diabetes
- □ heart disease
- □ infections
- □ pneumonia
- □ asthma
- □ digestive/stomach difficulties
- □ skin problems
- □ frequent stuffy nose
- □ ear infections
- □ migraine headaches
- □ arthritis
- □ lung difficulties
- □ epilepsy/seizures
- □ difficulty sleeping/snoring
- □ difficulty with feeding/swallowing
- □ difficulty gaining weight/growing
- □ hearing loss/sensitivity
- □ vision difficulties

Can you give some specific examples of the issues you're observing? _____

_____

_____

_____

Have you made an effort to correct problems at home or with other therapies? What have you done and what happened? _____

_____

_____

In your opinion, have her/his problems become better or worse? _____

_____

_____

Does anything seem to affect the severity of the problem? _____

_____

_____

Does she/he attend school or any extracurricular activities? Any difficulties there? _____

_____

How does she/he interact with other children? _____

_____

How does she/he respond when they are not understood? _____

_____

Does your child have any specialized equipment such as (please check all that apply)

□ walker □ stander □ wheelchair □ communication device □ orthodontic appliances

Is there any history of:

- □ thumb/digit sucking
- □ sippy cup use
- □ hair pulling
- □ open-mouth breathing
- □ tongue-thrust swallow pattern
- □ difficulty drinking from a cup
- □ difficulty eating from a spoon
- □ drooling
- □ picky eating
- □ difficulty with nursing/bottle or transitioning onto baby/table foods
- □ snoring/difficulty sleeping
- □ orthotics
- □ unable to attend in classroom
- □ short attention span
- □ unable to skip or ride bicycle
- □ sensitivities to food taste/textures/temp
- □ reactive to the way certain things "feel"
- □ does not like to be touched
- □ difficulty with self-care (i.e. toileting, brushing teeth, washing hands, dressing)
- □ difficulty with reading, writing or schoolwork
- □ dislikes swinging or feet leaving the ground
- □ frequent bumping into people/things
- □ a limited range of accepted foods
- □ clumsy or awkward movements

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Patient name:	DOB:	Today's Date:

What is your child's usual bedtime? _____

Has anyone commented that your child seems sleepy during the day? _____

Does your child:

- ☐ Snore more than half of the time?
- ☐ Always snore?
- ☐ Snore loudly?
- ☐ Have "heavy" or loud breathing?
- ☐ Breathe through their mouth at night?
- ☐ Have trouble, or struggle to breathe?
- ☐ Ever stop breathing during the night?
- ☐ Wake up during the night?
  How many times? _____
- ☐ Nap frequently?
- ☐ Bang their head in sleep?
- ☐ Sleep restlessly?
- ☐ Have leg pains?
- ☐ Breathe through the mouth during the day?
- ☐ Have a dry mouth in the morning?
- ☐ Occasionally wet the bed?
- ☐ Wake up feeling sleepy/have a hard time waking up?
- ☐ Have sleepiness during the day?
- ☐ Wake up with a headache?
- ☐ Have trouble with being overweight?
- ☐ Have nightmares?
- ☐ Scream during sleep?
- ☐ Grind their teeth during sleep?
- ☐ Sleepwalk?
- ☐ Kick while sleeping?

Is there anything else you feel we need to know about your child?

_____
_____
_____
_____
_____
_____
_____
_____